DX 2761 Referenced in Pearson Trial Decl.

Pearson, Bill [OBI]

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Sent:	Monday, October 09, 2000 3:04 PM
To:	Pearson, Bill [OBI]; Hirlak, Thomas [OBI]
Cc:	Dupre, Dan [OBI]
Subject:	US Oncology Analysis

Good afternoon!

This is an FYI only.....*this has not been shared with anyone else except for Dan.*

Attached is an analysis that provides insight into how USON looks at their world. This will be critical information in contracting with USON in the future.

I welcome any additional information that you might have to add to this analysis.

I am grateful to about 6 individuals (who will remain anonymous at their request). They were vital in helping me gather the pieces of the puzzle...all of their contributions are appreciated.

[redacted]
USON Margin Analysis.doc

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"CONFIDENTIAL ANALYSIS"

10/2/2000

US ONCOLOGY

FINANCIAL ISSUES

A. Margin

- **We hear from physicians, pharmacists, and corporate staff that they don't make enough margin on the drug**
- **OR...We hear that the more Procrit they use, the more money they lose**
- **OR...We hear that OBI needs to lower the price**
- **OR...We hear that Procrit is over-used in the network**

Analysis of possible reasons for these comments:

1. DC%DR: Drug costs as a percent of drug revenues
- USON analyzes cost of goods as a % of gross drug charges, and then drug is assigned a red, yellow, or green light depending upon its position in this analysis. This ratio drives access by the practice to the "reward pool"

a. DC%DR is calculated by taking acquisition drug cost (for Procrit they use $9.30) divided into the patient charge amount/drug revenue (for Procrit they use $26.00: AWP times 2.1). This is 35.76% which they round up to 36%. Therefore, the higher the AWP...*or*...the lower the acquisition price, will maximize the distance/spread and drive the % lower (like in a golf game, the lower the score, the better.

Examples of Drug used and the deviations from the target %:

Gemzar	11.2
Herceptin	11.1
Procrit	9.1
Taxotere	8.3
Neupogen	3.6

These deviations are above the target-so bad (yellow/red light)

Target 25%-28%; Must be below 28% for reward pool

Anzimet	9.3
Leukine	10.9
Leucovorin	22.1

These deviations are below the target-so good (green light)

b. Based on the information above, the target % is 25-28% for the mix of all of the drugs that a practice uses. If the practice's drug mix hits below the target 28% then they participate in the reward pool. If the practice's drug mix hits above the target 28%, then they are not eligible to participate, and therefore the physicians feel they "lose money." The key point, is that the target % is the overall mix of all drugs used. This is why physicians will say that when they use more Procrit they lose more money. If the mix of a particular practice is leveraged with high Procrit use, then it is possible that the practice's target % is above 25-28% and they are not eligible for the reward pool.

c. The practices want OBI to either lower acquisition price, or to raise AWP in order to increase the "spread" to get them below the 28%. They have told my that even if Amgen doesn't discount NESP that much, as long as it has a higher AWP and the ratio is better, then they will go with Amgen. So...if we get into a dual award situation with US Oncology, and Amgen's ratio is better, then USON will push the physicians will go with them.
The proof of this is with Anzimet and Leukine....even though the physicians will tell you that they prefer Zofran and Neupogen

Kathy Lokay delivers a 1 hour presentation at business meetings entitled, "Analyze COG as a % of Gross Drug Charges." All of the above issues are discussed. Neupogen is pointed out to be a "yellow-light drug" and Taxotere, Procrit...are "red-light drugs."
An example she uses to drive her point home about the benefits of watching the drug mix- For a practice that uses $10million in drugs, if they move their mix from the target 28% to 26%, then the practice saves $600,000.

B. Reimbursement

- **We hear from physicians, pharmacists, and corporate staff that they don't get reimbursed on the drug**
- **OR...We hear that there is "poor" reimbursement on the drug (translated this means that they aren't getting reimbursed as much as they'd like)**

Analysis of possible reasons for these comments:

1. If drug cost was lower, then the practice would have more money-an example from Kathy Lokay: every $1.00 saved, means an increase in $3.50 gross to the practice
2. If AWP was higher...then the 80% of AWP would be higher...so the practice would make more money.
3. If AWP was higher...then the 20% co-pay would be higher...so the practice would make more money either from the patient...or in the amount they are able to write-off.

- In terms of reimbursement, when physicians talk about not making enough money on the drug, they are actually saying that they want OBI to maximize the "spread" between acquisition cost, and the amount reimbursed (AWP)

4. Target is 45 days in AR, actual is 60-74 days in the practices that know what they are doing, much worse in the practices with problems. So there is a cash flow concern. The practices having problems are afraid of the "whistle being blown" about their problems, so they hide them as long as possible...some re-billing for over 2 years because they are afraid to say anything. When asked, the billing office just makes up a story that blames Procrit or Medicare. Even the practice administrators at many practices are afraid to step up and let OBI help.

5. Medical Necessity issues: When a patient goes above Hct of 33%, some practices hold the next dose instead of titrating, with the thought that they would re-start Procrit the following week after the Hct slips down a bit. However, no one monitors this...the patient's Hct falls and is not noticed until 3-4 weeks later. This causes the appearance of a roller coaster effect. When the paperwork goes in to Medicare, the physician's assertion of medical necessity is denied, because to Medicare it looks as though the product doesn't work on this patient and that medical necessity is not proven.

- For write-off purposes-Tax write-offs/credits are only on goods (the professional/technical component), not services. Practices can only write off "what they are out."
- The patient billed amount has no relevance in this discussion...the amount US Oncology usually uses when they say they have lost those large sums of money. The patient billed amount is only used by USON in the Margin Ratio on page one of this analysis-DC%DR.